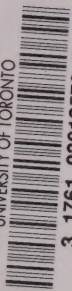


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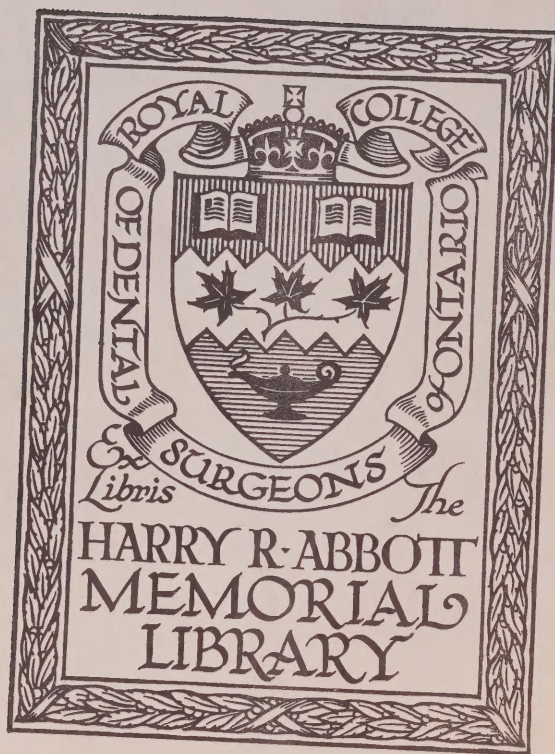


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Wypkema, C. and Hunt, A. M.

WOMEN AND DENTISTRY AS A PROFESSION:
A REVIEW PAPER.

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AS A PROFESSION

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A REVIEW PAPER

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Prepared by
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for the
Dental Health Care Services and Epidemiology
Research Unit
Faculty of Dentistry, University of Toronto
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WOMEN AND DENTISTRY AS A PROFESSION

On the basis of the following percentages of women dentists in Europe (Table 1), it seems ludicrous to question whether or not women can be successful dentists. They obviously can, as witnessed by the fact that more than 70 per cent of dentists in Latvia, Finland and the Union of Soviet Socialist Republics and large percentages of those in Denmark, Sweden, Norway and France are women. Attention should be given to the questions as to why so few women (less than 3.5 per cent) in North America are attracted to a career in dentistry, and how a larger number can be recruited into the profession. Waldman comments that the Survey of Dentistry (1960) established the general orientation that, because the supply of well qualified young men will not be sufficient to meet the future needs of the nation for specialized talent, and because women constitute the largest untapped source of talent, we should explore the possibility of recruiting women to study dentistry.

The number of women enrolled in Canadian dental schools in 1972-1973 was 148 or 8 per cent of the total enrollment. Out of the ten dental schools, the three schools with the highest percentage of females were Saskatchewan with 18.2 per cent, Laval with 16.1 per cent and Montreal with 13.0 per cent (Dental Education Register 1972-1973).

In 1971-1972, 334 women were enrolled in dental schools of the United States, representing 1.9 per cent of the student population. In 1972-1973, there was an increase to 511 women dental



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students, representing 2.9 per cent of the student population (Hillenbrand, 1973). The following discussion explores possible reasons for low enrollment and gives considerations to possible solutions.

The same problems that account for the low number of women in the dental profession prevail in other fields of work. One dominant concern of working women today is the urgent need and demand for day-care centres, another is the frequently made assertion that women have very short careers in dentistry. (It is felt that their short working span does not make it worthwhile to train them as opposed to male applicants). This is one of the reasons that there has been no active recruitment of women to enter the dentistry profession. In fact, women already in the profession or studying to be dentists, have frequently met outright discouragement or disapproval. Friend's (1973) finding that 75.7 per cent of women dentists who graduated between 1950 and 1965 from the University of Birmingham Dental School were still in full or part-time dental practice in 1971 offsets this negative argument. He further mentions the findings of a similar survey of Birmingham medical graduates conducted by Whitfield in 1964. Almost the same proportion of female graduates (74.2 per cent) were found to be actively engaged in medical practice, but the figures for part-time and full-time were almost the exact reversal of those given for dentistry (Table 11). Apparently, it is considerably easier to find part-time work in dental than in medical practice and for this reason the female medical graduate has been faced with a choice of full-time work or no work at all. Friend's (1973) survey

indicates ample opportunities for part-time work since only 3 of the 52 women dentists who tried to obtain part-time work had difficulty doing so. Even with the availability of part-time work, difficulties remain, particularly for the married women with young children. Many of these difficulties are cited in the survey. The lack of day-care facilities, the problems with domestic help, and the convenience of the available working hours are some of several problems. The fact that the salary of a domestic is not allowed as a tax deduction is also mentioned as a drawback of part-time practice, because it does not prove financially worthwhile.

Solutions

Waldman (1972) states that about 1 per cent of the dentists in the United States are women. The opportunity to work in a health maintenance centre might induce more women to think of dentistry as a career. He further says that "whereas most men dentists probably prefer to continue in private entrepreneurial practice, these health centres could employ women dentists who would prefer to arrange their working time to permit the combination of family life and professional career".

From the evidence at hand, women show a propensity to enter those types of practices which facilitate the combination of career and home life, but there must be other factors responsible for the pattern of male/female positions in the practice of dentistry. Chebib (1973) feels that discrimination may be a contributing factor towards the low number of women with formal training in specialities, particularly orthodontics and oral surgery. In

addition, there are no women to be found in administrative positions and few in teaching posts (Table III). Of course, there are more men than women in dentistry, but with over 200 women dentists in Canada, it is difficult to believe not one is qualified, willing and able to fill an administrative post!

Traditionally, women have tended the ill and cared for the children so that a North American's woman's choice of dentistry for a profession would seem to be a threat to a predominantly male occupation. Linn (1971) feels, specialization in paedodontics and orthodontics constitutes "a compromise that meets more conventional expectations about what kind of work women ought to do". Among the revelations in this exposition on women dental students (aptly subtitled: women in man's world), female students did acknowledge that male students and instructors suggested they plan on working with children. The examples of practical jokes played on female dental students and the generally discouraging atmosphere experienced during their studies, must act, to some extent, as a restraining influence on any aspirations to increased professional or administrative status.

Cowan, Reid and Fish (1973) found that few clinical faculty or male undergraduate students consider dentistry a suitable profession for a woman. This attitude, as well as the seeming failure to establish a serious recruitment campaign for women into the profession (starting with guidance counsellors in high school), in combination with the real problems of juggling a home life (marriage and children) with a career, account for the dismally low proportion of women dentists. Chebib (1973) concludes his section

on women in dentistry with a most provocative and an interesting statement: "...it is clear that women tend to enter the forms of practice e.g. salaried positions, pedodontics, and associateships which are increasingly being promoted as the settings for dental practice in the future". Therefore, it seems, the general current trend towards community health centre settings and away from the individual practitioner (medical and/or dental) will eventually prove advantageous to women. The transition, stubbornly resisted by the majority of men practitioners, will be beneficial for women.

Attitudinal, Educational and Administrative Changes

The transition towards community health centres will be a gradual one. Yet for Waldman (1972), the present era of generally heightened social awareness and the concomitant necessity for innovation in health services delivery, provides not only an opportunity but also a responsibility that the dental profession and its educational institutions cannot fail to meet. Starr (1972) proclaims the present time as propitious for well-qualified women to seek admission into dentistry. She feels that women represent an untapped source of manpower and that women presently occupied as hygienists should seriously consider the study of dentistry. In the face of the present trend toward additional duties for hygienists and the probable introduction of denticare within the near future, this idea seems plausible and logical. As Starr (1972) says, if the emphasis in dentistry is to be directed toward preventive care, who is better qualified to effect the shift in emphasis than women dentists who have been educated in preventive care and techniques? Levine (1971), long active in a campaign to

increase the number of women in dentistry, makes four suggestions to activate and facilitate this move. The first two definite areas of responsibility of educational administrators have been espoused for several years and are in practice in some form in some European countries. They are the establishment of day-care centres for communities and campuses and the development of curricula enabling women students to drop out of and return to programmes, as the demands of marriage and childbearing require. His latter two ideas concern a cultural, psychological change among the individuals in a society. He calls for a redefinition of male and female roles in society and with this the initiation of men into the traditional "wife's work" in the home. While these would certainly be welcome changes, they are impossible to dictate. They are changes in attributes, and as such, must and will evolve gradually. In the meantime, all health profession schools wishing to increase the enrollment of women will have to sensitize their male students and faculty to the actions and attitudes which make women uncomfortable. An attitudinal survey of educational experience by Austin, Maher and Lomonaco (1973) quotes some of the negative attitudes and discrimination experienced by female students. One girl was apparently told that, because she had been admitted, the male friend of a classmate had been denied a place. Generally, the female students did not seem to be taken seriously, but rather were exposed to anti-feminist and sexist jokes in introductory lecture material. (And most likely were labelled as humourless if they did not appreciate these wisecracks). Some girls reported that they had been asked to stay away from the year-end class dinner.

Degrees of sensitivity and types of reactions towards these negative expressions will vary from individual to individual. (The object of a crude joke, one leaves in tears, where another would decide to respond in kind). Also, while one tries to diminish the differences between herself and her male colleagues by being 'one of the boys', another may say, I admired those who wished I was not there. I did not like them to think I was one of the fellows. One woman student reported dating another student until the jibes of his fellow students caused him to stop seeing her.

Linn (1971) does make the heartening observation that not all schools are similar in these respects. At one school, a woman dentist said that the women students had dated with the male students, although they had similar experiences to the ones described in his paper. To gain a forceful insight into the situation of a woman in a dental school, it is very interesting to read all the specific comments of women students and dentists, in Linn's exposé in particular, and also in the paper by Austin, Maher and Lomonaco. Both papers suggest that an increase of the number of women in professional schools would likely diminish most of these negative attitudes. One respondent described her life as a female student as a state of "psychological disenfranchisement". Students generally missed female companionship and felt a lack of women advisors and deans available for counsel. The observation that women faculty members did not receive equal rank, salary or office accommodations similarly marks women as "second-class" citizens. The authors make the following valid analogy: "Sexist attitudes and actions have no more place in the health professions than do racist attitudes

and actions. There should be no assumption that women are any less committed to their professions than are male colleagues". This statement could be extended to consider that women who are in the profession or professional schools are perhaps even more committed than their male colleagues, since they are there despite all the odds and barriers discussed. Finally, it is interesting to note that no significant difference was found between the responses of current students and the responses of alumnae. The same negative attitudes were apparently experienced by female medical students. The general consensus of all respondents can be summed up as a feeling that they were never quite fully accepted as students.

Recruitment and the Future

Organizational changes in the delivery of health care will necessitate certain emendations and redefinitions of the roles of the various health professions and their relationship to each other. The changes will in turn require of individual practitioners, a break from the traditional past, and a broader, more flexible outlook generally. This seems particularly necessary in dentistry. When today a shift towards dental care plans, public health programmes and the use of expanded duty type of auxiliaries seem inevitable, these considerations become acutely important. Waldman (1972) claims that pre-dental requirements for dentistry may be a large contributing factor to the final product of dental schools. He feels that the usual requirements for entrance into dentistry actually preclude the achievement of a liberal education. Almost of necessity then, the entering class is largely made up of students who lack the benefits and value of such an education. In fact, Waldman goes on to describe

the dental student as conservative, conforming, unconsciously aggressive, persistent, methodical, somewhat rigid and unflexible and with motives of upward mobility and financial betterment. Conversely, students who had majored in or emphasized the humanities and social sciences beyond the minimum requirements, were more concerned with and involved in community activities and had marks equal to or better than the students who studied sciences in pre-dentistry courses.

Waldman held discussions to determine what innovations would be necessary to attract students with an arts background to a career in dentistry. He found that these students were more amenable to dentistry as a possible career only after certain departures from solo practice per se were suggested. They approved of neighbourhood health centres of hospital based arrangements. Waldman (1972) says essentially, "the potential interaction with members of the other health and social welfare professions seemed to offer the student the possibility of doing more for the patient than 'just filling teeth'". This concern for the dentist to do more to meet the patient's total needs was a dominant one in the discussions. Interestingly, similar ideas were presented in Mustard's (1974) Report of the Health Planning Task Force in Ontario. The idea of 'doing more' was presented more as a reflection of their own impersonal contact with their dentists, rather than a positive goal. They were negative towards a practice employing a series of expanded duty hygienists, apparently, because of the assembly-line aspect of this arrangement. The possibility of a salaried position as opposed to the assumption of risks and problems of private entrepreneurial practice was definitely preferable. Students declared the latter type of practice incongruous with the practitioner's avowed desire to serve the needs of the community.

The fields of research and administrative positions in health care plans were considered very attractive and interesting when opportunities were made known.

A survey of attitudes among dental students and faculty attributes many of the above preferences and beliefs of arts students to the women among the respondents (Cowan, Reid, Fish, 1973). For example, a larger percentage of female dental students strongly agree that a public dental programme should operate as a closely integrated part of total health services and that all health services are a right and not merely a privilege, compared to the percentages of male students. A justification of this difference was made with the discovery that, had they not been admitted to dental schools, many of the females students would have entered another health care profession and that their orientation was towards health rather than business. In conjunction with this seemingly more liberal attitude of female dental students was their definition of a dentist's role. More female students saw the dentist as an integral part of the community. Forty-seven per cent of female students were found to agree strongly that dentists should participate in non-dental community health and welfare groups, compared with only 32 per cent of male students. The only area where female students held conservative views was in response to expanding the hygienists' role. The fact that public health dentistry and pedodontics are the two fields of dentistry that have endorsed and, most importantly, maximized the expansion of duties for hygienists may explain this attitude. It is also these two specialties where women dentists have been traditionally able to find a practice haven.

In summary, both these groups - the non-predental students and women dental students - view the dentist's role ideally as more comprehensive and more flexible than it has been traditionally. It is in this context that women in dentistry are in the forefront of the profession: a situation aptly described in Chebib's paper, "it is clear that women tend to enter the forms of practice which are increasingly being promoted as the settings for dental practice in the future". As well, Mustard's Report of the Health Planning Task Force (1974) proposes the concept of group arrangements as one of the key elements in health care delivery of the future.

A growing and heightened awareness of the need to rectify the underutilization of women as dentists in Britain and North America does exist and will definitely increase their numbers in the profession. In 1956, the Report of the Committee on Recruitment to the Dental Profession, Scotland, cited a general ignorance in the high schools towards dentistry as a profession. In particular, it specified that girls did not consider dentistry an avocation because they felt they lacked the strength necessary to practise the profession. The report enumerated qualities which make women "eminently suitable members of the dental profession." These include a gift for handling children, common to most women and particularly useful in dentistry and "a natural aptitude for any healing art." In addition, the report declared dentistry ideal for married women inasmuch as part-time work is readily available, thereby facilitating the execution of home chores while making a substantial contribution to the needs of the country." The report recommended that steps be taken to ensure that girls, girls' schools and parents become fully aware of the dentistry profession.

Current evidence does indicate an increase of women in dentistry in Britain. Seward and Walker (1974) found that 13.8 per cent of dentists were women. This compares with a general university enrolment of 30 per cent women. In studying the available figures, they discovered women in the United Kingdom to have met with considerable success when applying to dental schools recently (Table IV).

The 1971-72 figures show that 60 per cent of women who applied for admission were accepted as compared with 41 per cent of male applicants. The authors estimate that by 1980, 30 per cent of dental graduates will be women. The discussion concludes with the suggestion that a retainer scheme for dentistry be initiated, similar to the one developed for doctors. The Women Doctors' Retainer Scheme was introduced for the married woman temporarily unable to practice medicine due to home responsibilities. Its aim was to encourage these women to remain in touch with their professional activities and to continue their involvement and training, thereby facilitating the resumption of practice, once they are free to do so. The authors explain that a similar scheme for women dentists "would reduce and eventually eliminate the need for expensive retraining, ...and ensure the retention of valuable work potential within the profession..." - a factor of great economic importance, should the trend of increasing women dental graduates continue. The attempt to develop this scheme indicates awareness of the problems involved for women dentists; that in itself is a hopeful, progressive sign.

In Canada too, progress is being made albeit slowly. In 1971, the following recommendations were made by Cappa in the Ontario Dental Association Journal:

"If dentistry is to attract a reasonable share of (these) bright young students, we must take steps to promote our profession as a career for women. Perhaps we should start by attempting to change the image of dentistry through our public relations so the public becomes more aware of our true role in the health sciences. We could also communicate with the guidance departments of our secondary schools, so they will be aware of the opportunities available to their female students in our profession".

Have these ideas been acted upon? The figures as they stand would seem to indicate a negative answer or a very slow beginning. In 1971, the percentage of women dental students enrolled in Canadian schools was 6.6, in 1974 it was 8.0 (Dental Education Register 1971 and 1974). According to Pauline Jewett et al. (1963), "it is largely traditional assumptions about acceptable roles for women which are responsible for the paradox that, while trained and competent women are urgently needed in a variety of professional and academic areas of activity, society is reluctant to take steps to make use of the resources available to it..." These traditional assumptions become for Gelber (1973) 'sex ghettos in the health professions' where "some of the health professions are almost wholly manned by women, paradoxical as that may sound; others consist almost wholly of men". Jewett (1968) notes that not only are 91 per cent of the practising physicians and 97 per cent

of the dentists in Canada men, but that, conversely, more than 90 per cent of the professional workers in fields of occupational therapy, physiotherapy, dental hygiene and nursing are women. In other words, men have experienced difficulty entering certain 'traditionally' female occupations. Percentages for women in medicine in European countries are considerably higher than those for Canada and the United States. The same holds true for pharmacy. Gelber (1973) describes conditions which exist in these sex ghettos, observing that the lowest levels of pay are to be found in the so-called female professions and that even when the same job is being done by men and women, women get paid less. this disparity was the subject to a suit brought before the Ontario Court of Appeal in 1970, involving male orderlies and nurses aides. A decision was won in favour of the nurses aides. A provincial law now requires that equal remuneration must be paid for equal work. Strides are being made. The establishment of the Royal Commission on the Status of Women, itself was an achievement. The resultant hearings, which were held across the country, brought to light many issues and inequities. The concern now is to initiate implementation of as many recommendations in the Royal Commission as possible, as soon as possible. the particularly high costs of dental education may have posed a deterrent for some women in the past, especially as there are not as many high paying summer jobs open to women as there are to men. One important step has been made since the Commission report, which will facilitate the financing of education for a small group of women. Women candidates for the Canadian Forces are now eligible for subsidized training at civilian universities (Council on

the Status of Women, 1974). The opening of these plans to female applicants is viewed as a means of providing equality in terms of career development. If one considers the Canadian Forces as a rather conservative entity within Canada, women can see this as a bold gesture to break down traditional confines. When one views the Canadian Forces as an understaffed and underequipped organization, it becomes a lightly veiled attempt at recruitment. Until the contributions and capabilities of the so-called weaker sex are recognized by organizations and institutions such as these, only women will be able to find solace in a remark such as this made by Charlotte Whitton:

"Whatever women do, they must do twice as well as men to be thought half as good. Luckily, it's not difficult".

TABLE I

Women as Percentages of the
Total Number of Dentists
in Selected Countries

Country	Percentage
Latvia S.S.R.	80
Finland	72
U.S.S.R.	70
Denmark	40
Sweden	30
Norway	25
France	25
England	11
Canada	3.5
United States	1.5

Source: Hunt, A.M. - From various sources
during sabbatical leave study of
dental services in Europe, 1972-1975.

TABLE II

Women Who Remain in Practice
Following Graduation
(Great Britain)

	DOCTORS	DENTISTS
PART-TIME	21.1%	46.7%
FULL-TIME	53.1%	29.0%
	74.2%	75.7%

Source: Friend, L.A. "The Career Commitment of
Female Dental Graduates." Br Dent J 135:
23, 1973.

TABLE III

Type of Work by Salaried Dentists
Registered in 1970, by Sex

TYPE OF WORK	NUMBER EMPLOYED		TOTAL
	MALE	FEMALE	
ADMINISTRATIVE	105	0	105
TEACHING	363	7	370
CLINICAL	577	51	628
RESEARCH	9	0	9
PREVENTIVE DENTISTRY	1	0	1
TOTAL	1,055	58	1,113

Source: Chebib, F.S. Dentists in Canada - A Study of Movement and Distribution 1957-1970. Faculty of Dentistry, University of Manitoba. p. 110, 1973.

TABLE IV

Applications and Acceptances
Dental Schools in the
United Kingdom

		Applied	Number Accepted	Percent Accepted
1969	Male	923	555	60.1
	Female	247	209	84.6
1970	Male	1,141	628	55.0
	Female	301	208	69.1
1971	Male	1,436	587	40.9
	Female	475	285	60.0

Source: Seward, M.H. and Walker, D.G.
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